# Child Fatalities: Avoidable Tragedies

In 2004, 16 month-old Justice and 6 week-old Raiden Robinson were found dead in their home. In 2005, four year-old Sirita Sotelo was beaten to death by her stepmother. Each of these deaths shocked the conscience. They unmasked our society's inability to protect our most vulnerable. These high profile deaths galvanized advocates, politicians, parents, community members, and other citizens to take action.

Within months of the Robinson children's deaths, the Washington Legislature enacted the Justice and Raiden Act. The Justice and Raiden Act[1] allows Child Protective Services (CPS) greater ability to intervene in cases of chronic neglect. Sirita's death led to Sirita's Law, which called for a state task force to reform the child welfare system in Washington.[2] Both of these laws were inspired by the lessons learned from tragedies. They are a vivid example of positive systemic reform that can arise from a detailed review of a child fatality and a critical examination of the shortcomings in the child protection system. Other states have responded legislatively when they too have been devastated by the death of a child.[3]

**The Ombudsman reviewed the fatalities of Justin and Raiden Robinson and Sirita Sotelo and developed recommendations to address:**

- ✓ improving procedures for case reviews;
- ✓ implementing caseload standards;
- ✓ modifying statutory provisions governing investigations and interventions;
- ✓ requiring mental health evaluations in certain cases;
- ✓ strengthening case supervision;
- ✓ assuring appropriate services are provided; and
- ✓ improving assessment of other adult caregivers.

[1] ESSB 5922 sets forth the Legislature's intent that DSHS and the justice system intervene in cases of chronic neglect, where the well-being of a child is at risk and specifically includes a parent's substance abuse as an important factor in determining whether negligent treatment or maltreatment exists.

[2] "Sirita's Law" was named after four year-old Sirita Sotelo who was beaten to death by her stepmother in Lake Stevens, Washington. "The bill started as a three-strikes law for parents who abuse or neglect children, but it was modified to call for a task force to study the safety of children in the child welfare system." http://seattlepi.nwsource.com/local/224440_billsign16.html (Seattle PI, May 16, 2005)

[3] For example, in 1994, 7-year-old Megan Kanka was lured away from her home, raped, and killed. Megan's death led to Megan's Law, which increased community knowledge about sex offenders by providing the public with certain information on the whereabouts of sex offenders so that local communities could protect themselves and their children. Megan was a New Jersey girl who was raped and killed by a known child molester who had moved across the street from the family without their knowledge. In the wake of the tragedy, the Kankas sought to have local communities warned about sex offenders in the area. All states now have a form of Megan's Law. http://www.meganslaw.ca.gov/homepage.aspx?lang=ENGLISH. In 1996, 9 year-old Amber Hagerman was abducted and murdered while riding her bicycle in Arlington, Texas. Amber's death led to the creation of the Amber Alert System in 1996. Broadcasters team with local police to develop an early warning system to help find abducted children. AMBER stands for America's Missing: Broadcast Emergency Response. Other states have now implemented their own AMBER plans. http://www.amberalert.gov/faqs.html.

## OFCO Reviewed the High Profile Child Fatalities of Justice and Raiden Robinson and Sirita Sotelo[4]

In 2004 and 2005, the Ombudsman reviewed the fatalities of Justice and Raiden Robinson and Sirita Sotelo at the request of the state Legislature. Based on reviews of these child fatalities, the Ombudsman developed several recommendations. The recommendations from the Justice and Raiden Robinson fatality review addressed:

- improving procedures for case reviews by CPS supervisors;
- implementing caseload standards for CPS workers and supervisors;
- modifying the statutory provisions governing CPS investigations and interventions; and
- requiring CPS to attempt to obtain mental health evaluations of a parent when mental health issues contribute to the alleged child abuse or neglect.

The recommendations from the Sirita Sotelo Fatality Review addressed:

- strengthening case supervision following a child's return to a parent's care;
- assuring that appropriate services for successful reunification are provided; and
- improving assessment of other adult care-givers in the parent's home.

## JUSTICE AND RAIDEN ROBINSON

On November 14, 2004, 16-month-old Justice Robinson and six-week-old Raiden Robinson were found dead in their home. The children died of malnutrition and dehydration, despite food in the refrigerator and pantry. Police officers had been summoned to conduct a welfare check on the children, and a two-year-old child assisted the officers in opening the front door. Uncooked food was scattered throughout the home, indicating that the two-year-old child had been foraging for food for some time. The responding officers found the children's mother, Marie Robinson, intoxicated and passed out in a bedroom. Police officers also discovered over 300 empty beer cans in the mother's bedroom.

Ms. Robinson's history of alcohol abuse, and the related risk of harm to her children, was well known to Child Protective Services (CPS). Prior to the children's death, CPS received six referrals between 2002 and 2004 reporting chronic alcohol abuse by the mother and related physical neglect of the children. Two referrals were accepted for CPS investigation, two referrals were referred to Alternative Response Services (ARS),[5] and two referrals were screened as "information only" and were not investigated.

The Office of the Family and Children's Ombudsman conducted a case investigation of CPS' involvement with this family and the circumstances leading to Justice and Raiden's death.[6] The Ombudsman

[4] The full text of the Ombudsman's fatality reviews of the Robinson and Sotelo children is available at http://www.governor.wa.gov/ofco/reports.htm.

[5] Alternative Response Systems (ARS) "provide delivery of services in the least intrusive manner reasonably likely to achieve improved family cohesiveness, prevention of re-referrals of the family for alleged abuse or neglect, and improvement in the health and safety of children." These services are voluntary and are not intended to be investigative for purposes of determining whether child abuse or neglect occurred. RCW 74.14D.020

[6] Shortly after deciding to conduct an investigation, several legislators contacted the Ombudsman requesting a case investigation.

reviewed all records and reports from CPS, available treatment reports from service providers, ARS records, as well as applicable Children's Administration (CA) Policy and Procedure, and state law. The Ombudsman also interviewed CA staff. The purpose of the Ombudsman's investigation was to determine whether CPS responded to reports of child neglect secondary to Ms. Robinson's alcohol abuse, in a manner consistent with department policy and state law, and to identify changes in law, policy and procedure that will better protect children from abuse and neglect.

## Justice and Raiden Fatality Findings

1. **CPS investigation and case activities were not completed in a timely manner**. For example, CPS failed to complete an investigation within 90 days of a referral received on February 7, 2004.[7] This referral was accepted for a high standard investigation. CA procedures required, at that time, that in a high standard investigation the assigned social worker must "interview child victims face-to-face within 10 working days from the date of referral."[8] On March 1, 2004, 23 calendar days and 15 working days after the referral was received, the CPS worker completed an initial face-to-face interview with the mother, father and two children. The referral remained open at the time of Justice and Raiden's death, nine months later.

2. **CPS investigations were inadequate and insufficient.** In the course of its investigations, CPS did not obtain relevant collateral information from sources such as medical professionals, law enforcement, or service providers.[9] For example, on October 8, 2003 CPS accepted for investigation a referral stating: the mother just completed drug/alcohol treatment 30 days ago and has now relapsed; the children were filthy, had feces all over and had urinated in their pants; and they had not been fed and were starving.

   CPS failed to obtain the children's medical records, or interview medical providers, regarding allegations that the children were filthy and starving. A review of medical records[10] shows that while CPS was conducting its investigations, Justice was seen by a pediatrician on October 29, 2003 for failure to thrive, he had not gained weight in the past month, and in the four months following his birth, he had dropped from the fiftieth to the tenth percentile in weight. Because no inquiries were made, this information was not known to CPS, and the correlation between the mother's binge drinking and the child's failure to thrive was not addressed.

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[7] Children's Administration Practices and Procedures Guide, Section 2520 states: "The social worker shall complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation and no later than the 90th day after the referral is received unless the requirement is waived by the supervisor . . . ."

[8] Id. Section 2331(D)(2). On August 8, 2005, at the direction of Governor Gregoire, DSHS implemented a requirement that social workers must now interview child victims within 72 hours of moderate to high risk referrals. Interviews must take place within 24 hours in emergent cases.

[9] Id. Section 2331(D)(27) states: "The assigned social worker must: . . . Interview . . . professionals and other persons (physicians, nurse, school personnel, child day care, relatives, etc.) who are reported to have or, the social worker believes, may have first-hand knowledge of the incident, the injury, or the family's circumstances."

[10] The children's medical records were obtained by DSHS CA after repeated requests by the Ombudsman in the course of the Ombudsman's fatality review.

3. **Inadequate factual basis to support CPS' investigative findings.** CPS' conclusion that the referral received on October 8, 2003 was "Unfounded"[11] for child abuse or neglect, was not adequately supported by the information available to the CPS worker. Specifically, the allegation was not refuted that the children were filthy, had feces all over and had urinated in their pants, had not been fed and were starving at the time of the mother's relapse. Additionally, the mother admitted a history of alcohol abuse, treatment and relapse. Moreover, there was no independent information in support of CPS' conclusion that the mother was hospitalized due to low potassium levels, not alcohol consumption, and no independent information regarding the health and welfare of the children.

4. **CPS case records contain several instances of inaccurate or misleading entries.** In each case, these statements minimize the gravity of the mother's history of alcohol abuse or the potential risk to her children. For example, an Investigative Assessment of December 11, 2003 erroneously states "No prior hx [history] with WA CPS." At that time however, the mother had two prior reports to CPS alleging alcohol abuse and related neglect, which were referred to ARS. This Investigative Assessment also stated: "Mother appears to understand addiction process well and sees how she needs to maintain sobriety." The worker failed to record in this assessment that the mother's alcohol evaluation states that Ms. Robinson had not committed to treatment at that time, and that she failed to comply with an agreed Safety Plan. Similarly, a Transfer/Closing Summary dated December 16, 2003 also omitted information that Ms. Robinson did not engage in recommended treatment.

5. **CPS Service Agreements failed to compel the mother to engage in services or reduce the risk to her children.** Twice CPS entered or offered a service agreement, requiring the mother to seek treatment for her alcohol abuse. When these attempts were unsuccessful, CPS did not take additional steps to compel the mother to seek treatment.

6. **Alternative Response Systems (ARS) services failed to adequately assess or address the mother's needs.** In September 2002, CPS received two referrals concerning alcohol abuse, mental health, and child safety issues. Instead of opening these referrals for CPS investigations, they were accepted and referred to the Alternative Response System, which provides services but does not conduct investigations.

7. **Inappropriate Screening Decision by CPS Intake.** Two CPS referrals received in September 2002 were referred to ARS, and were not investigated by CPS. The second referral, received on September 17, 2002, stated that the mother had been hospitalized for suicidal ideation, that she was discharged on that date (9/17/02) and was still expressing concerns about hurting herself. The referral also stated that the mother reported there was no food in the home, and that the mother lived alone with her six month-old baby.

   This referral was initially accepted for CPS investigation, with a risk tag of 5. After reviewing the referral, the CPS intake supervisor reduced the risk tag from 5 to 2 stating: "ARS Wkr [worker] is

[11] Children's Administration Practices and Procedures Guide, Section 2540(A) provides: at the conclusion of a CPS investigation, "the worker must complete a CAMIS Investigative Risk Assessment (IRA) which includes: . . . a record of case findings regarding alleged abuse or neglect. [Findings are based on the following definitions:] (a) **Founded** means: Based on the CPS investigation, available information indicates that, more likely than not, child abuse or neglect as defined in WAC 388-15-130 did occur. (b) **Unfounded** means: Based on the CPS investigation, available information indicates that, more likely than not, child abuse or neglect as defined in WAC 388-15-130 did not occur. (c) **Inconclusive** means: Following the CPS investigation, based upon available information, the social worker cannot make a determination that, more likely than not, child abuse or neglect did or did not occur."

involved with services and client is receptive to services." CA Practices and Procedures permit the intake supervisor to change the risk tag and screening decisions when "additional information supports the change."[12] Here however, there is no documentation, either by the intake supervisor, or the ARS worker, that the supervisor obtained information from ARS regarding specific services provided to Ms. Robinson or the level of her compliance.

## Justice and Raiden Fatality Recommendations

### Recommendations Regarding Children's Administration Policy

- **Improve Supervisory Reviews of CPS Investigations.**

  High quality and timely supervisory reviews are essential to ensuring that investigations are conducted in a manner consistent with best practices and agency policy and procedure.

- **Case referral to Alternative Response Systems should not preclude investigation by CPS.**

  CA Policy should be amended to provide that in addition to providing ARS services, CPS may conduct investigations into allegations of child abuse or neglect.

- **Implement Caseload Standards.**

  In order for CPS workers to conduct thorough and timely investigations, assess risk and child safety, engage families in essential services, and monitor case progress, CA must establish and implement reasonable caseload standards. While computing caseloads is an inexact science, the Child Welfare League of America (CWLA) recommends that CPS workers be limited to 12 active investigations per month.[13] CA should use this as a guide in determining and implementing caseload standards.

### State Law Recommendations

- **Modify the statutory definition of child abuse and neglect and allow CPS to intervene earlier in an investigation to protect children at risk of abuse or neglect.[14]**

  The Legislature should consider amending the definition of child neglect, to recognize the harm that may result from an act or omission, or pattern of conduct, that constitutes a substantial danger to the child's health, welfare or safety, and allow earlier CPS intervention. The Legislature should consider changes to statutory provisions regarding child abuse and neglect, permitting the court to establish an in-home dependency for the purpose of implementing appropriate service and safety plans. A parent's failure to comply with a service plan or safety plan is a relevant factor which should be considered when determining whether conditions present a substantial threat of harm to the child.

- **Require CPS to attempt to obtain an evaluation when it is determined that mental health issues are a contributing factor to the alleged child abuse or neglect.**

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[12] Id. Section 2220(F)(2).

[13] CWLA Guidelines for Computing Caseload Standards, http://www.cwla.org/programs/standards/caseloadstandards.htm.

[14] The Ombudsman previously made this recommendation in the Office of the Family & Children's Ombudsman 2000 Annual Report. The Legislature modified the definition of abuse and neglect by passing ESSB 5922.

When substance abuse is a contributing factor to alleged child abuse or neglect, state law requires CPS to cause a comprehensive chemical dependency evaluation to be made.[15] Similar statutory requirements should exist to identify and treat mental health issues contributing to the neglect or abuse of a child.

## SIRITA SOTELO

Three weeks before she was born, Sirita[16] Sotelo was the subject of a CPS referral, alleging prenatal substance abuse by her mother. After she tested positive for cocaine at birth on February 12, 2000, CPS filed for dependency and placed Sirita in foster care.

Over the next three years, the department made numerous attempts to reunite Sirita with her mother. Services were provided to address the mother's substance abuse and mental health issues. Four times Sirita was placed with her mother, only to again be removed due to allegations of abuse or neglect. During this period, Sirita experienced seven different placement episodes, alternating between foster care and placement with her mother. She spent over 25 months in foster care, in eight different foster homes,[17] and 19 months placed with her mother. Significant periods of placement with the mother lasted four months, five months and ten months. While efforts were being made to reunite Sirita with her mother, the child's father, Mr. Ewell, who was notified of the dependency action, did not involve himself in the dependency process, or seek placement of Sirita.

In May 2003, the department filed for termination of parental rights, based on the length of time Sirita had been in state care, the failed reunification attempts with the mother, and the father's lack of participation in the dependency action or reunification efforts. However, after learning that the department was seeking to terminate parental rights, Sirita's father stepped forward and requested that she be placed with him and his wife. The department then conducted a home study and developed a service plan for the father, which included a drug/alcohol assessment, parenting classes, weekly visits with Sirita, and a psychological evaluation. The father successfully completed these services, and in November 2003, Sirita was placed with her father, stepmother and their four children.

Over the following 12 months, the department continued to supervise Sirita's placement with her father and provide case management services. Monthly visits to check on Sirita's health and safety occurred in December 2003, January 2004, February 2004, and the last visit occurred in May 2004. Although caseworkers identified a need for counseling, this service was not implemented. In November 2004, the dependency was dismissed, as the father had established a parenting plan gaining custody of Sirita.

On January 22, 2005, only two months after the dependency case was closed, CPS received a referral from law enforcement reporting a suspicious death of four-year-old Sirita. The stepmother and another relative had been with Sirita the night of her death and reportedly called poison control stating that Sirita had gotten sick eating glue. Later that evening, the relative checked on Sirita and found her dead, and then called 911. According to law enforcement, the child appeared gaunt, malnourished and pale. Medical examiners later determined she died as a result of blows to the head and body causing a fractured skull and severed liver. The stepmother later stated that she couldn't handle Sirita's fits and tantrums and admitted she threw her in a cold shower and beat her after the child wet her pants.

[15] RCW 26.44.170.

[16] Case records list various spellings of the child's name, including Sereta, Sireta, and Serita.

[17] Length of placement in any one foster home ranged from one night to 13 months.

The Ombudsman conducted a case investigation of the Division of Children and Family Services' (DCFS) involvement with Sirita and her parents. The Ombudsman reviewed all records and reports from DCFS, treatment reports, professional evaluations, as well as applicable CA Policy and Procedure and state law. The purpose of the Ombudsman's investigation was to determine DCFS' compliance with department policy and procedure, and state law, and to identify changes in law, policy and procedure that will better protect children from abuse and neglect.

The Ombudsman identified the following areas of concern:

- Lack of services provided to Sirita, her father and stepmother, following her placement in their care.
- Delay in establishing permanency for Sirita.
- Frequency of health and safety checks did not comply with CA policy.
- The father's and stepmother's CPS referral history may not have been fully considered prior to placing Sirita in their home.
- Although the father completed both a psychological evaluation and drug/alcohol assessment prior to Sirita's placement, there was no similar evaluation of the stepmother.

## Sirita Fatality Findings

1. **DCFS delayed establishing permanency for Sirita.** Ideally, a safe, stable and permanent home for a dependent child should be achieved before the child has been in out-of-home care for 15 months.[18] In this case, Sirita was the subject of a dependency action for over three and a half years before a permanent placement with her father was established. Before she was placed with her father, Sirita experienced seven different placement episodes, alternating between foster care and placement with her mother. During this time, Sirita spent a total of over 25 months in foster care, and 19 months placed with her mother.
2. **The father's and stepmother's CPS history may not have been considered.** The screening decision not to investigate the CPS referral received in March 2001, regarding one of the Ewell's children was not clearly inappropriate or unreasonable under the circumstances according to existing CA policy.[19] As a result of this screening decision, however, concerns regarding substance abuse and criminal conduct in the home were never investigated. Additionally, the department's consideration of Mr. Ewell as a potential caregiver for Sirita, erroneously concluded he had a clean slate with CPS. Although the CPT presentation summary briefly mentioned the March 2003 CPS referral stating that the father allowed Ms. Sotelo unsupervised access to his child, the summary states that there was a minimum level of risk in placing Sirita with her father,

[18] RCW 13.34.145(1)(c).

[19] Children's Administration Case Services Policy Manual, Section 2131(C) states:
"The department shall investigate complaints of any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or that presents imminent risk of serious harm, and on the basis of the findings of such investigation, offer child welfare services in relation to the problem to such parents, legal custodians, or persons serving in loco parentis, and/or bring the situation to the attention of an appropriate court, or another community agency: Provided, that an investigation is not required of non-accidental injuries which are clearly not the result of a lack of care or supervision by the child's parents, legal custodians, or persons serving in loco parentis." See also RCW 74.13.031.

in part because he had "no apparent involvement with CPS concerning his own children." Although a CPT presentation summary was prepared by the caseworker, the CPT did not occur. Consequently, a CPT did not review this case prior to the child being placed with the father.

3. **DCFS did not fail to evaluate Mrs. Ewell pre-placement.** The department did not fail to evaluate Mrs. Ewell and her capacity to provide adequate care for Sirita prior to placing her in the Ewell's home. Mrs. Ewell participated in the home study, and complied with a criminal background check. But the department did not seek further assessment or evaluation of her ability to care for Sirita. This was not clearly unreasonable under the circumstances, as the department lacked specific information or concerns that would have warranted further evaluation. However, information presented during Mrs. Ewell's criminal proceedings described events from her personal history that clearly would have justified further assessment regarding her ability to care for Sirita.
4. **Frequency of health and safety checks did not comply with existing policy.** Although both CCS and CWS caseworkers conducted home visits after Sirita was returned home, these visits did not occur with the frequency or consistency required by then existing department policy. Children's Administration Policy, in effect in 2003 - 2004, required that during the first 120 days of a child being placed back in the home, contact with the child must occur at least twice a month for children age birth through five. Sirita was placed in her father's and stepmother's home in November 2003. The CCS caseworker visited the home in December 2003, January 2004 and February 2004, in order to check on Sirita's health and safety. The CWS caseworker visited the home in May 2004. No further health and safety checks occurred after May 2004, even though the department was responsible for supervising this case for an additional 6 months.
5. **Lack of services provided to Sirita and her father and stepmother.** The predominate area of concern was the lack of services to Sirita, her father, and her stepmother following Sirita's placement in the Ewell's care. Caseworkers noted that support services were needed to assist the father and stepmother to address Sirita's behavior issues. These services, however, were not provided.

## Sirita Fatality Recommendations

- **Heightened assessment of non-parent adult caregivers in the home.**

  Policymakers should require greater assessment of other adults in a parent's home, if it is likely that such person will be providing care for a dependent child on a regular basis. Stepparents or partners of a parent may be thrust into a position of providing daily care for a child with whom they are neither bonded nor related.[20] Their ability to care for a child and their family background is relevant to assessing the child's safety and welfare in the home. A criminal background check of other adult caregivers and a general home study are not sufficient to fully address these issues. At the very least, current home studies should specifically address in detail the extent and nature of care provided by other adults in the home, examine bonding/attachment issues between the child and such adults, and explore whether further evaluation/assessments of an adult caregiver is warranted.

[20] Lack of attachment between child and caregiver, and a caregiver's ambivalence towards the child, are factors identified in previous fatality reviews. See, ZyNia Nobles Fatality Review, Rafael Gomez Fatality Review and Justice and Raiden Robinson Fatalities Review.

- **Revise and implement policy requiring regular health and safety checks for children returned to a parent's care.**

  In 2001, Children's Administration implemented policy[21] requiring in-home contact with the child, twice a month, during the first 120 days of in-home placement, for children age birth to five. After the first 120 days, visits must occur at least monthly. Although this policy has remained in effect since 2001, these requirements have not been incorporated into either the Practices and Procedure Guide, or the Case Services Policy Manual. The absence of these requirements creates confusion as to whether health and safety checks for dependent children placed in a parent's home are required.

- **Increase efforts to provide services once a child is returned to a parent's care.**

  In addition to requiring regular and consistent in-home contact between the caseworker and the child and parent, the department should increase efforts to provide services to a child and family once a child is returned home. Existing tools, such as safety plans and service contracts, should be utilized to assure that families engage in appropriate services. The case record should specifically document steps taken to provide services.

[21] Children's Administration Policy 01-02,"Case Management Requirements for In-Home Dependencies" (Effective May1, 2001; revised November 1, 2002).